STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING 00 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF LAFAYETTE	300 WINDY HILL DRIVE LAFAYETTE, IN47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of complaint number IN00088759 Complaint number IN00088759 Substantiated, Federal/State deficiencies related to the allegations are cited at F223 and F225. Survey dates: April 18, 19 & 20, 2011 Facility number: 000147 Provider number: 155243 AIM number: 100266900 Survey Team: Linda Campbell, RN, TC Census Bed Type: SNF/NF: 139 Total: 139 Census Payor Type: Medicare: 30 Medicaid: 86 Other: 23 Total: 139 Sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on April 21, 2011 by Bev Faulkner, RN			
F0223 SS=B	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from abuse related to verbal abuse and misappropriation of resident property for 3 of 9 residents reviewed for abuse in a sample of 9. (Residents D, G, H). Findings include:	F0223	F 223**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility followed its policy and procedure for identifying, reporting and investigating allegations of abuse for Residents D, H and G. Appropriate disciplinary action to include termination of employees for substantiated abuse was conducted per policy. 1. Resident D's report was investigated according to facility policy and substantiated. The employee was discharged. Resident D discharged from Regency Place on 3/29/11 2. C.N.A. #5 reported the incident involving resident H immediately. The incident was investigated and substantiated. Employee C.N.A. #6 was terminated. 3. The facility immediately began an investigation upon notification of the incident regarding resident G. C.N.A. #7 was terminated.**How other residents having the**	04/24/2011

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	1. A "Fax/Incident Reporting Form" dated 3/30/11 indicated "...On 3/29/11 in the early morning (Resident D's name) complained that she was yelling out several times and wanted someone to help her to her recliner. After several times of yelling out (CNA #1's name) came in and told her if she didn't (sic) not quiet down she would cover her face with the nebulizer mask. (Resident D) stated that she was worried the rest of the night and about		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** All residents have the potential to be affected. **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur** Staff has been re-educated on the policy and procedure for abuse to include identifying, reporting, protecting the resident and investigating. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place,** Staff will be randomly (1 staff member per shift, 3 times weekly)questioned regarding the abuse policy. Administrator and/or designee will report findings to the Performance Improvement team monthly for three months and then quarterly to ensure ongoing compliance. Residents will be randomly questioned (interviewable residents 4 per shift, 3 times weekly) regarding staff treatment of residents. Administrator and/or designee to report findings to the Performance Improvement team monthly for three months and then quarterly to ensure ongoing compliance. Findings and system components will be reviewed by	

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	being kicked out of the facility...CNA was placed on administrative leave immediately pending the investigation...the complaint was substantiated and (CNA #1's name) was terminated on 4/4/11..." A handwritten statement signed by RN #2 indicated "...(CNA #3) stated that '(Resident D) just said she was scared and the short red hair girl had threatened her saying that she would be kicked out if she didn't		the Performance Improvement Team with subsequent plan of correction developed and implemented as deemed necessary.	

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	stop coughing and take her breathing treatment. By short hair, red hair c (with) glasses meaning (CNA #1)...So (RN #4) went to ask (Resident D) what happened. (RN #4 came back and said the same statement..." A handwritten statement signed by CNA #3 indicated "(Resident D) asked (CNA #1) to get in her chair. (CNA #1) told her she couldn't. Later in the shift, I answered (Resident D's) light. She was upset told me that the girl with short red			

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	hair and glasses had told her if she didn't stop coughing she would send her out of here. I didn't hear any of that. I did hear (CNA #1) tell her she couldn't get in her chair...." Resident D's closed clinical record was reviewed on 4/19/11 at 5:15 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, syncope and collapse, chronic kidney disease, and			

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	hypertension. A Minimum Data Set (MDS) 30-day assessment, dated 2/22/11, indicated the resident was moderately impaired in cognitive decision-making skills, had poor appetite, and required extensive one-person physical assistance with bed mobility, transfer, and toilet use. A nurses' note, dated 3/29/11 at 3:30 A.M., indicated "Pt (patient) verbalizes that 'short red			

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	hared (sic) girl with glasses told me I'm keeping everyone awake and threatened to kick me out of here.' Pt is alert and oriented...(CNA #1) says 'I asked her to please use the call light because hollering is keeping roommate awake and assured call light within reach.'..." A social service note, dated 3/29/11 at 12:15 P.M., indicated "F/U (follow up) conversation c (with) resident about incident c (with) CNA last night...she states			

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	after several episodes (of resident yelling) CNA came in and told her that if she didn't quiet down she would cover her face c (with) nebulizer mask. Resident states she did not sleep the rest of night and was worried about being kicked out..." An employee file for CNA #1 was reviewed on 4/19/11 at 5:20 A.M. A "Performance Improvement Form," dated 8/20/09, indicated "CNA was short/rude with a resident. Res (resident) asked for			

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	coffee, CNA told res that coffee wasn't important, she had people to get up...Final written warning (indicated by X)...any further problems R/T (related to) rudness (sic) to residents could result in termination..." A "Performance Improvement Form," dated 4/4/11, indicated "...allegation of verbal abuse from (Resident D)...seperation (sic) due to allegation of abuse...substantiated...dis charge (indicated by			

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	X)... Interview on 4/18/11 at 12:30 P.M., with the DNS (Director of Nursing Services) indicated the resident had told two nurses and a CNA that CNA #1 said she would be kicked out of the facility and a mask would be put over her face. She indicated the stories were "consistent." She indicated Resident D was frightened but was assured CNA #1 wouldn't take care of her again. The DNS indicated CNA #1 did			

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	not work in the building after the allegation and was terminated on 4/4/11. 2. A "Fax/Incident Reporting Form," dated 11/12/10, indicated "... (CNA #5) came to DNS office and reported during the change of shift, (CNA #6) and herself were transferring (Resident H) to bed. (CNA #6) was complaining about the day and (Resident H) attempted to ask (CNA #5) and (CNA #6) something. (CNA #6)			

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	told (Resident H) to 'shut up' and acted like she was going to slap the back of his head. (CNA #5) reported the incident immediately. (CNA #6) was placed on administrative leave immediately...(CNA #6) was terminated and DNS explained to her behavior was inappropriate...." A typewritten statement, dated 11/3/11, indicated "...(CNA #5) and I were caring (sic) on conversation among each other and (Resident H)			

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	repeated something actually mumbled something. I looked at him and said oh be quiet. It's ok were (sic) going to lay you down..." An undated handwritten statement signed by CNA #5 indicated "...she was trying to explain the drama of her day to me as we were getting (Resident H) ready to lay down. He was trying to speak and she said 'shut up' though him trying to talk. Then she raised her hand as if to back hand him. She was behind him			

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	so he couldn't see. I told her that wasn't right, that I didn't want to hear the gossip. I'm sure she wouldn't have actually hit him, althou (sic) it was a very cruel gesture..." Resident H's closed clinical record was reviewed on 4/19/11 at 7:10 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, senile dementia, pneumonia, and chronic airway			

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	obstruction. A MDS assessment, dated 12/16/10, indicated the resident was severely impaired in cognitive decision-making skills, had long- and short-term memory problems, and required extensive one-person physical assistance for bed mobility, transfer, and toilet use. An employee file for CNA #6 was reviewed on 4/19/11 at 5:00 A.M. Documentation was lacking related to any			

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	previous episodes of abuse by the CNA. Interview on 4/18/11 at 12:30 P.M. with the DNS indicated the CNA had been terminated for verbal abuse. The CNA had told the resident to "shut up" but had not hit the resident. She indicated there had been no previous incidents of abuse by the CNA. 3. A "Fax/Incident Reporting Form" dated 12/20/10 indicated "On 12/10/10 at 0130 (1:30 A.M.), (Resident G was			

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	transferred from Regency Place of Lafayette to (hospital name)...(Resident G's) wife (name) and her mother (name) came in to get (4) $40 gift cards from (Resident G's) wallet that he had purchased earlier in the month. (Resident G's) wallet was locked in the med cart with $23 cash, his bank card and his receipt for the gift cards. The 4 gift cards were not in his wallet. The wife and mother-in-law searched his items with staff assistance, no gift			

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	cards were found. The wife and mother-in-law then went to Walmart and Walmart stated the cards were spent at the (name of city) Walmart at 0330 (3:30 A.M.) on 12/11/10. The wife and mother-in-law did make a police report and would have been able to watch the surveillance tapes on Monday. While the wife and mother-in-law were at Regency Place on 12/18/10 they were discussing the issue at the desk with the staff. The DNS was notified at			

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	this time and an investigation was initiated immediately. (CNA #7) overheard the discussion and later in the shift reported to (LPN #8) that he had 'spent the gift cards.' (CNA #7) told (LPN #8) that he 'found them in the shower room,' he knew that they were not his and he spent them. (LPN #8) immediately notified the DNS and (CNA #7) was placed on Administrative Leave immediately. (LPN #8) and (CNA #7) also notified the police and he			

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	was arrested for theft on 12/18/10 at 2100 (9:00 P.M.)...(CNA #7) was terminated on 12/20/10. DNS contacted the police and made a statement..." The facility reimbursed the resident for the $160 gift cards. Resident G's clinical record was reviewed on 4/18/11 at 11:55 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, necrotizing facieitis, sacral decubitus, diabetes			

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	155243	A. BUILDING 00 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF LAFAYETTE	300 WINDY HILL DRIVE LAFAYETTE, IN47905

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	mellitus, psych (psychological) disorder, and history of pulmonary embolus. An MDS 5-day assessment, dated 3/30/11, indicated the resident was independent in cognitive decision-making skilled, was totally dependent on two-person physical assist for bed mobility, and was totally dependent on one-person physical assistance for toilet use. Interview on 4/19/11 at			

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	7:35 A.M., with Resident G indicated the resident had four $40 gift cards in his wallet. He went to the hospital and his wife and mother-in-law came to the facility to pick them up. They were gone. He indicated "the CNA knew they were there because I had asked him to get $10 from my wallet before." He indicated he had no previous problems with theft at the facility. CNA 7's employee file was reviewed on 4/19/11 at 4:40 A.M. A			

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	"Performance Improvement Form" dated 12/20/10 indicated "...(1) allegation of theft substantiated. (2) facility did reimburse $160...was arrested for theft et (and) on Walmart video..." A criminal history check, dated 4/28/09, indicated CNA #7 had two misdemeanor charges for operating a vehicle while intoxicated in 2004. One charge was dismissed and the other had no resolution available for review.			

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	Documentation was lacking related to any previous occurrences of theft. Interview on 4/18/11 at 12:30 P.M., with the DNS indicated Resident G's family had come to get the gift cards. The CNA told a nurse he had taken them. The family went to the police and the CNA was arrested for theft. The CNA was seen on camera spending them. The DNS indicated there had been no previous issues related to theft and the			

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	family was reimbursed. The CNA was terminated. Review on 4/18/11 at 1:15 P.M., of a facility policy and procedure, dated 7/11/10, provided by the Staff Development Coordinator, and titled "Responding to and Investigating an Abuse Allegation" indicated "...For All Abuse Allegations...Call the police, if required by law and follow their instructions if there is an alleged:...Theft of			

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	resident property...If allegations against an employee are substantiated, a. terminate employment..." Review on 4/18/11 at 1:15 P.M. of a facility policy and procedure, dated 4/28/09, provided by the Staff Development Coordinator, and titled "Protection of Resident During an Investigation" indicated "...A staff member(s) implicated in an abuse/neglect situation, regardless of discipline, will be: a.			

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	immediately removed from any resident contact. b. interviewed and version of event documented. c. suspended pending investigation results. 3.1-9(b) 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of verbal abuse was investigated and reported to the Indiana State Department of Health for 1 of 1 residents in a sample	F0225	F 225 **What corrective action(s) will be accomplished for those residents found to have been affected by the**	04/24/2011

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	of 9. (Resident I). Findings include: A handwritten note, dated 3/30/11, documented as a resident interview as part of an abuse investigation by the SSD (Social Service Director), indicated "(Resident I)...(CNA #1) left her on the bed pan and yelled at her. She doesn't want (CNA #1) around her. Happened several nights recently..." Resident #I's clinical record was reviewed on 4/18/11 at 1:20 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, anxiety, dysphagia, and cerebrovascular accident. A Minimum Data Set (MDS) assessment, dated 4/8/11, indicated the resident was moderately impaired in cognitive decision-making skills, was able to recall items with cuing, required extensive one-person assistance for bed mobility and transfer, and was totally dependent on one-person physical assistance for toilet use. Interview on 4/18/11 at 12:50 P.M., with the Director of Nursing Services in attendance, with Resident #I indicated CNA #1 yelled at her when she was on the		**deficient practice?** Resident I was assessed on 4/18/11 by the DNS for signs and symptoms of anxiety or distress related to the incident reported on 3/30/11. The resident did not exhibit any signs of distress or anxiety related to the incident reported on 3/30/11. The incident reported on 3/30/11 was reported to the Indiana State Board of Health on 4/18/11. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** All residents have the potential to be affected. **What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur** The Director of Nursing, Administrator and Director of Social Services have been re-educated on the policy and procedure on identifying, reporting, protecting a resident and investigating an allegation of abuse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place,**	

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	bedpan telling her she had to get off in ten minutes." Interview on 4/18/11 at 12:55 P.M., with the DNS indicated the incident was not investigated or reported to the Indiana State Department of Health. She stated "I misread the investigation." Interview on 4/18/11 at 1:00 P.M., with the Social Service Director indicated Resident #I told her CNA #1 had yelled at her regarding being on the bedpan. Review on 4/18/11 at 1:15 P.M. of a facility policy and procedure, dated 7/22/10, provided by the Staff Development Coordinator, and titled "Responding to and Investigating an Abuse Allegation" indicated "...For All Abuse Allegations...Begin an internal investigation...Report the alleged abuse to the appropriate state agencies in accordance with state law..." Review on 4/18/11 at 1:15 P.M., of a facility policy and procedure, dated 6/30/06, provided by the Staff Development Coordinator, and titled "Conducting an Investigation" indicated "...Federal regulation requires a center have evidence that all allegations of abuse, neglect, and exploitation/misappropriation, including		A Performance Improvement tool has been developed that will monitor facility compliance of abuse Policy & Procedures. The Administrator and/or designee will complete the PI weekly. Findings will be reported to the PI team monthly for 3 months and then quarterly to ensure ongoing compliance. Findings and system components will be reviewed by the Performance Improvement Team with subsequent plan of correction developed and implemented as deemed necessary.	

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	injuries of unknown source, are thoroughly investigated...Submit the findings to the State Survey Agency within 5 working days of the initial incident or per state regulations, if applicable..." 3.1-28(d) 3.1-28(e)			